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No. __-___

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY, PETITIONERS

v.

WANDA GLENN

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Sixth Circuit erred in holding, in conflict with two other Circuits, that the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a "conflict of interest" which must be weighed in a judicial review of the administrator's benefit determination under *Firestone Tire & Rubber* v. *Bruch*, 489 U.S. 101 (1989)?

2. Whether the Sixth Circuit erred in holding, in conflict with six other Circuits, that an ERISA claim administrator must consider and refute in its written disability determination a decision, without the underlying record, of a Social Security Administration administrative law judge?

PARTIES TO THE PROCEEDINGS

The parties to the proceedings at the Sixth Circuit are the Petitioner-Defendants, Metropolitan Life Insurance Company, the Long Term Disability Plan for Associates of Sears, Roebuck and Company and the Respondent-Plaintiff, Wanda Glenn. There are no other parties.

RULE 29.6 STATEMENT

Petitioner, Metropolitan Life Insurance Company, is a wholly owned subsidiary of MetLife, Inc., which is a publicly traded company. No publicly held entity owns 10% or more of MetLife's stock.

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INTRODUCTION

Petitioners, MetLife (Metropolitan Life Insurance Company) and Long Term Disability Plan for Associates of Sears, Roebuck and Company, respectfully petition for a writ of certiorari to review the September 1, 2006 decision of the United States Court of Appeals for the Sixth Circuit. That decision, following prior Sixth Circuit precedent, held that (1) the fact that a claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits, without more, constitutes a conflict of interest which must be weighed on judicial review of the claim administrator's benefit determination, and (2) a bare opinion by an administrative law judge of the Social Security Administration, without any of the underlying testimony or exhibits, must be considered and specifically rebutted in the determination of the ERISA claim administrator. Each of these holdings conflicts with decisions in other circuits, contravenes Congress' purposes in enacting ERISA, and otherwise merits this Court's review.

OPINION BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit reversing the decision of the United States District Court for the Southern District of Ohio is reported at 461 F. 3d 660 and is reproduced in the Petitioners' Appendix. Pet. App. 1. The opinion of the District Court is not reported and is reproduced in the Appendix. Pet. App. 2. The opinion of the administrative law judge of the Social Security Administration regarding respondent's claim for Social Security disability benefits is reproduced in the Appendix. Pet. App. 3.

JURISDICTION

The judgment of the Court of Appeals was entered on September 1, 2006 and the time for filing this petition was extended by Justice Stevens to January 2, 2007. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") provides in pertinent part:

> Any employee benefit plan may provide—(1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator).

29 U.S.C. § 1102(c)

> Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from - . . .
>
> (3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

29 U.S.C. § 1108(c)

STATEMENT

On June 20, 2000, respondent Wanda Glenn applied for and received disability benefits under an ERISA-regulated plan provided by her employer, Sears Roebuck & Company. (JA 288-290[1]) MetLife approved respondent's claim for benefits under the plan's definition of disability for the first twenty-four months. Subsequently, respondent applied for Social Security disability benefits and an administrative law judge of the Social Security Administration held that she was totally disabled and entitled to Social Security benefits. (JA 322-326, 331-336) In July 2002, MetLife notified her that her benefits would be reevaluated under the plan's definition of disability applicable to claims after the first twenty-four months of benefits. (JA 170-172) Respondent submitted the Social Security administrative law judge's determination of total disability in support of her claim but failed to submit

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[1] References to the Joint Appendix to the Sixth Circuit are preceded by "JA".

the underlying medical opinions and testimony. (JA 170-172) MetLife reviewed the entire record, including the medical reports, and determined that respondent was not "completely and continuously unable to perform the duties of any gainful work." (JA 198-201) Petitioners thus terminated her long-term disability benefits.

Respondent appealed the denial of her long-term disability benefits by filing a Complaint in the United States District Court for the Southern District of Ohio pursuant to 29 U.S.C. § 1132(A). (JA 4-6) The District Court denied respondent's Motion for Judgment on the Administrative Record and granted Petitioners' Cross Motion for Judgment on the ground that Petitioners' determination was not arbitrary and capricious. (JA 104-122)

A panel of the Sixth Circuit reversed. Purporting to apply this Court's decision in *Firestone Tire & Rubber* v. *Bruch*, 489 U.S. 101 (1989), the panel first found that "we are entitled to take into account the existence of a conflict of interest that results when, as in this case, the claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits and to factor in the claim administrator's failure to give consideration to the Social Security Administration's determination that Glenn was totally disabled." Pet. App. 2a. The panel noted that the district court, consistent with Sixth Circuit precedent, "identified this conflict of interest as a relevant factor in determining whether an abuse of discretion had taken place." *Id.* at 10a. However, the panel faulted the district court for failing to "include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight." *Ibid.* Accordingly, the panel found that "this factor did not receive appropriate consideration by the district court." *Ibid.*

The panel also faulted the district court (and MetLife) for failing to give what it considered appropriate weight to the

Social Security Administration's ("SSA") prior decision in respondent's favor. According to the panel: "That MetLife apparently failed to consider the Social Security Administration's finding of disability in reaching its own determination of disability does not render the decision arbitrary per se, but it is obviously a significant factor to be considered upon review." *Id.* at 15a.

The panel then reversed the District Court, holding that "MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process, MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration." *Id.* at 24a.

REASONS FOR GRANTING THE PETITION

The Sixth Circuit's decision is the latest manifestation of a mature, deep and acknowledged conflict among the circuits on two important questions in ERISA law. The first is whether an ERISA claim administrator that also funds the plan benefits has a "conflict of interest" that must be considered on judicial review of the administrator's benefit determination under this Court's decision in *Firestone*. There the Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citation omitted). Interpreting that statement, the Sixth Circuit holds, along with the Fourth, Fifth, Eighth, Ninth and Eleventh Circuits that such a possible[2] conflict

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[2] Courts have variously labeled the relationships, in which an ERISA administrator is also a funder of the plan, as a possible, a potential, an inherent, an apparent, a standard, an actual and a structural conflict of interest. The Court used the term "possible conflict" in *Firestone Tire & Rubber Co.* v. *Bruch* 489 U.S. 101, 115 (1989) and this petition follows that convention.

must be considered and weighed by the court.[3] The First and Seventh Circuits, by contrast, hold that such a possible conflict, without more, is not something that a court must weigh in determining whether the administrator's decision was arbitrary.

The second question is whether a bare decision, without the underlying testimony and exhibits, of an administrative law judge of the Social Security Administration must be specifically considered and refuted in an ERISA administrator's benefit determination. Here again the circuit courts are divided in an entrenched split of authority. The Sixth Circuit holds, along with the First and Second Circuits, that such a bare decision must be considered by the ERISA administrator. The Seventh, Eighth, Ninth, and District of Columbia Circuits hold that such a bare decision need not be considered and refuted in the ERISA administrator's determination.

Each of these questions demands this Court's resolution, and this case provides an excellent vehicle with which to do so.

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[3] This possible conflict is applied in a number of ways. Some circuits find that it changes the standard of review. *E.g. Carolina Care Plan Inc.* v *McKenzie* 467 F.3d 383, 386 (4th Cir. 2006). Other circuits find that it changes the burden of proof. E.g. *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006-7 (10th Cir. 2004). Still other circuits, as in this case, hold that it is evidence of an abuse of discretion by the ERISA administrator. E.g. *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled in part by Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L.Ed.2d 1034 (2003). The question presented in this petition is not what effect a possible conflict should have but whether a possible conflict of interest should have any effect at all.

I. This Court Should Review And Reverse The Sixth Circuit's Holding That The Fact That An ERISA Claims Administrator Also Funds the Benefits, Without More, Creates a Conflict That Must Be Considered and Weighed on Judicial Review.

As noted, the Sixth Circuit holds that there is an actual conflict of interest when an insurance company both decides whether an employee is eligible for benefits and pays those benefits and that this conflict should be taken into account as a "factor in determining whether the decision was arbitrary and capricious." *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled in part by Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 834 (2003); *Calvert* v. *Firstar Finance Co.*, 409 F.3d 286, 292-3 (6th Cir 2004); *Peruzzi* v. *Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998). Following those precedents in this case, the Sixth Circuit found that it was "entitled to take into account the existence of a conflict of interest that results when as in this case, the claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits." Pet. App. 10a. The court thus held that this fact, standing alone, creates a conflict of interest that must be considered and weighed on judicial review.

A. The Sixth Circuit's Rule Squarely Conflicts with Decisions in Two Other Circuits.

There is a clear split among the circuits on this question. The First and Seventh Circuits hold that the fact that an administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits, without more, does not create a conflict that must be "weighed" as part of the judicial review described in *Firestone*. As the First Circuit has explained, the natural potential for a conflict of interest in that situation is countered by other market forces (employers' desires to please their employees) which offset the risk that the insurer will be "overly tight-fisted."

Wright v. *R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-5 & n. 5 (1st Cir. 2005) (recognizing and commenting on the conflict in the circuits).

Similarly, the Seventh Circuit held in *Mers* v. *Marriott International Group Accidental Death and Dismemberment Plan* 144 F.3d 1014, 1020, (7th Cir 1998), "We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict... The existence of a potential conflict is not enough.... Mers has not established an actual conflict or a significant one. In fact, she offers no evidence that a conflict exists other than her theory of an inherent [potential] conflict. This production is not enough to show an actual bias." (Citations omitted)

The Seventh Circuit reached the same result, on similar analysis, in *Chojnacki* v. *Georgia Pacific*, 108 F.3d 810 (7th Cir. 1997). Speaking of alleged "structural conflicts" arising from claims administrators that play dual roles, the Court observed:

> "We have rejected similar claims of conflict of interest. In *Chalmers* v. *Quaker Oats Co.*, for example, an unfunded ERISA plan was administered by a committee made up of the corporation's officers. 61 F.3d 1340, 1344 (7th Cir.1995). We found no conflict of interest, noting that ERISA endorses the idea that a corporate officer can also serve as a plan administrator. We explained that in such cases the 'impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrator's partiality.' *Id.* In support, we pointed out that Quaker Oats' annual revenue was over $6 billion, so the company was unlikely to "flinch at paying out $240,000." *Id.* Finally, we noted that companies who develop reputations for being tight-fisted when it comes to paying benefit claims

might have trouble attracting new talent and be forced to pay higher wages. *Id.*"

Thus, in all three decisions – *Mers, Choimacki and Chalmers* -- the Seventh Circuit concluded that a merely structural conflict does *not* establish the kind of "conflict of interest" that must be weighed in the judicial review contemplated by *Firestone*.

These decisions, like the First Circuit's decision in *Wright*, obviously conflict with the Sixth Circuit's holding here that the possible conflict of a claims administrator who also funds plan benefits is enough to establish "the existence of a conflict of interest" for purposes of judicial review under *Firestone*. Pet. App. 10a. If the Sixth Circuit had followed the rulings of the First and Seventh Circuits, it could not have reversed the district court's decision based on its view that petitioner's "dual roles" established a conflict of interest.

B. Six Other Circuits Also Consider An ERISA Administrator's Dual Roles As Evidence Of A Conflict of Interest

The Sixth Circuit's holding is consistent with rulings in six other circuits, thereby establishing a 2-7 circuit split on this issue. Specifically, the Third, Fourth, Fifth, Eighth, Ninth and Eleventh Circuits hold that the fact that an ERISA administrator also funds the plan, without more, creates a conflict of interest that must be considered and weighed in a judicial review. For example, the Fourth Circuit in *Carolina Care Plan Inc.* v. *McKenzie* 467 F.3d 383, 386 (4th Cir. 2006) stated that "We have consistently reduced the deference afforded to administrators based on the "mere" fact that they also insure the plan and thus profit by denying claims." Thus, these circuits hold that the "mere" fact that the funding source is also the claim administrator is sufficient to require consideration and "weighing" of a conflict of interest on judicial review under *Firestone*. *Accord Pinto v. Reliance*

Standard Life Ins. Co., 214 F.3d 377, 393 (3rd Cir. 2000); *Wildbur* v. *ARCO Chem. Co.*, 974 F.2d 631, 638-42 (5th Cir. 1992); *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998); *Abatie* v. *Alta Health & Life Ins. Co.* 458 F.3d 955, 968 (9th Cir. 2006); *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006-7 (10th Cir. 2004); *Brown* v. *Blue Cross & Blue Shield of Ala. Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990)

To be sure, these circuits disagree among themselves as to the *effect* of such a conflict on the nature and scope of judicial review (a disagreement that is not the subject of the present petition). As noted, in the Fourth Circuit, such evidence simply "reduce[s] the deference afforded to administrators." 467 F.3d at 386. In the Tenth and Eleventh Circuits, by contrast, a possible conflict of interest shifts the burden to the claim administrator to prove that its decision was not affected. *Fought* v. *UNUM Life Ins. Co. of Am* , 379 F.3d 997, 1006-7 (10th Cir. 2004) (holding that administrators acting under a possible conflict of interest have the burden of showing that their decision to deny disability benefits is supported by substantial evidence); *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990) (holding the decision of a plan administrator's with a possible conflict is presumptively void and shifting burden of proof to insurer). In the Third, Fifth and Eighth Circuits, the possible conflict triggers a sliding scale standard of review in which the possible conflict is considered as evidence of an abuse of discretion. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3rd Cir. 2000); *Wildbur* v. *ARCO Chem. Co.*, 974 F.2d 631, 638-42 (5th Cir. 1992); *Woo* v. *Deluxe Corp.*, 144 F. 3d 1157, 1161 (8th Cir. 1998). The Ninth Circuit, while rejecting the sliding scale analysis, requires the district court to consider the "inherent conflict" arising from an insurer's dual roles as a factor in determining how much deference to afford the administrator. *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 968 (9th Cir. 2006) ("A district court, when faced with all the facts and circumstances, must decide in

each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might.")[4]

However, all of these circuits agree, contrary to the rulings of the First and Seventh Circuits discussed above, that the mere existence of these dual roles constitutes a conflict of interest that must be "weighed" when a court conducts the review required by *Firestone*. This conflict, which is ultimately a conflict over the proper interpretation of that decision, could hardly be more stark.

C. The Sixth Circuit's Holding is Incorrect.

As noted, the Sixth Circuit relied in part upon the petitioners' "dual function" to find that petitioners' disability denial was an abuse of discretion. That conclusion, however, and similar conclusions by the other six circuits that follow this approach, is incorrect for two fundamental reasons.

First, the Sixth Circuit's approach contravenes Congressional purposes in enacting the statute. Congress was aware of the widespread practice of appointing plan funders as claims administrators and nevertheless authorized employers to appoint claims administrators that are also funders of

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[4] The Second Circuit has gone both ways on this question. Compare, *e.g.*, *Pagan* v. *NYNEX Pension Plan*, 52 F.3d 438, 443 (2d Cir. 1995), with *Jordan* v. *Retirement Committee of Renssalaer Polytechnic Inst.*, 46 F.3d 1264, 1274 (2d. Cir. 1995)..

If the Court ruled that the kind of potential conflict or structural conflict at issue in this case—and present in many others—is not a "conflict of interest" for purposes of a *Firestone* analysis, many of these cases could easily be resolved solely on that basis, without a court's having to reach the issue of what *effect* the alleged conflict may have on the court's review.

the plan. Indeed, ERISA specifically provides that "[a]ny employee benefit plan may provide – (1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator)." 29 U.S.C. § 1102(c). Congress also explicitly provided in, 29 U.S.C. § 1108(c)(3), that 29 U.S.C. § 1106 (specifying prohibited transactions) shall not be construed so as "to prohibit any fiduciary . . . from serving as a fiduciary in addition to being an officer, employee agent, or other representative of a party in interest." ERISA thus envisions that a fiduciary "may 'wear two hats,' one of a trustee or fiduciary and one of a settlor." *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1005 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005). As stated by the Court in *Pegram* v. *Herdrich*, 530 U.S. 211, 225 (2000), "...the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats."

In spite of the language of ERISA, some circuits have attempted to discourage employers from appointing claims administrators that also fund the plan. As the Eleventh Circuit puts it, "one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises." *Brown* v. *Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990). In other words, even though Congress specifically permitted employers to appoint ERISA claim administrators who are also funders of the benefit plan, some courts are using treating that practice as a "conflict of interest" in an effort to discourage employers from making those appointments.

Such efforts contravene Congress' purpose. ERISA was passed not only to protect the rights of beneficiaries but also

to encourage employers to create and maintain voluntary benefit plans, *see* H. R. Rep. No. 533, 93d Cong., 2nd Sess. 1, reprinted in 1974 U.S.C.C.A.N. 4639, *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996), and "to maintain the premium costs of [the ERISA] system at a reasonable level." 29 U.S.C. § 1001b(c)(5). This Court has emphasized both "the public interest in encouraging the formation of employee benefit plans" and "the need for prompt and fair claims settlement procedures." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987), overruled in part by *Ky. Ass'n of Health Plans, Inc.*, v. *Miller*, 538 U.S. 329 (2003). In *Varity Corp.*, 516 U.S. at 497, the Court pointed out that courts should take into account Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans." Congress permitted employers to appoint claims administrators that also fund the plan benefits to encourage employers to adopt voluntary employee benefit plan. The Sixth Circuit rule penalizes employers merely for appointing a claim administrator that also funds the benefit plan even though the law specifically authorizes that appointment.

Second, the Sixth Circuit's approach–like that in the other circuits that also consider the mere presence of "two hats" as creating a conflict—ignores economic reality. For example, the benefit requested in this case compared to the annual income of MetLife is negligible. Recognizing this, a number of courts have rejected the categorical generalization that claim administrators will act in their own self-interest in making benefit decisions. As the Seventh Circuit put it in a case involving this petitioner:

> Although MetLife acts as both a claim administrator and a funder of the plan, that factor, standing alone, does not constitute a conflict of interest. *See Chalmers* v. *Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). Indeed, it has

> not been demonstrated that MetLife has a direct stake, in terms of its own financial health, in the outcome of this issue of interpretation. *See Cuddington* v. *Northern Ind. Pub. Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994) (refusing to find a conflict on a similar theory absent "specific evidence showing that the [claim administrator] had a conflict of interest").

Cozzie v. *Metropolitan Life Ins. Co.*, 140 F.3d 1104, 1108 (7th Cir. 1998).

By contrast, the Sixth Circuit's holding wrongly stereotypes claim administrators by assuming that they will inevitably place their own putative short-run interest over the interest of the plan beneficiary. The assets and annual revenues of most insurance companies and employers that serve as claim administrators exceed the amount potentially awarded in a benefit claim by a huge margin. There is no legitimate reason to make a categorical assumption that a claim administrator will deny a claim to make a contribution to the company's annual profits. In fact, the company may not have any self-interest. As the Seventh Circuit noted, an insurance company that serves as a claim administrator "may not have any stake in the decision. . . . For many large firms, health and disability insurance on their labor forces is retrospectively rated. This means that the employer agrees to reimburse the insurer for all outlays, plus a loading charge and administration fee." *Perlman* v. *Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999). For that reason, "[w]e have no reason to think that [the insurance company's] benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases." *Id.*

The Sixth Circuit was wrong to ignore these considerations in concluding that the mere fact that an ERISA administrator is statutorily permitted to "wear two hats" is enough

to establish a conflict of interest that must be weighed during judicial review of the administrator's benefit decision.

D. The Court's Resolution Of This Issue Is Vital And This Case Is An Ideal Vehicle For Resolving It.

This Court's resolution of the first question presented is vital for three reasons. First, it will enable the Court to achieve one of ERISA's "principal" goals, which is to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001), quoting *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). When it enacted ERISA, Congress intended,

> [T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflict directives . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995), quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990).

Despite this Congressional purpose, the Sixth Circuit applies a conflict of interest rule directly contrary to the conflict of interest rule used by other circuit courts. "Uniformity is impossible" if different circuits subject decisions by administrators to different legal obligations. *Engelhoff*, 532 U.S. at 148. Because of the split in the circuits, an administrator of a national benefit plan may have a benefit decision accepted in the First or Seventh Circuits and have the same benefit decision under the same plan rejected by the Sixth Circuit. Only this Court can bring resolution to this issue.

Second, as acknowledged by the circuit courts, the issues are clear and well developed and the conflict is wide, exten-

sive and mature. *Wright* v. *R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005); *Pinto* v. *Reliance Std. Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000)

Third, there cannot be any doubt that this conflict in the circuits is desperately in need of resolution. During the past two decades, hundreds of judges have labored over whether an ERISA administrator's status as a plan funder taints the administrator's benefit decision. The lower courts have expressed a desire for further guidance. As stated in *Pinto* v. *Reliance Std. Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir 2000), "courts have struggled to ... to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." Indeed, the D.C. Circuit has recently commented in *SBC Pension Benefit Plan - Non Bargained Program*, 366 U.S. App. D.C. 1, 8 (D.C. Cir. 2005), that this Court's "opaque direction about how courts should review discretionary benefits denials by potentially conflicted [plan] fiduciaries 'in ERISA cases has' bedeviled the federal courts 'ever since.'" *Firestone* was decided. (citation omitted).

Given the conflict among the circuits, the desire for further guidance, and the vast amount of time being spent on these issues by the circuit and district courts, there is no reason to let this issue remain unresolved any longer.

This case is also a compelling vehicle for resolution of the conflict. The Sixth Circuit's reasoning is clear, the relevant facts are well-developed and the issues clearly defined. Accordingly, this case provides an ideal vehicle by which the Court can choose among the various approaches and, in so doing, resolve the circuit conflict outlined above.

II. The Sixth Circuit's Holding That A Claim Administrator Must Specifically Consider In Its Determination A Bare Decision By The Social Security Administration Also Warrants Review.

The Sixth Circuit's holding that an ERISA administrator must give weight to a bare decision by an administrative law judge of the Social Security Administration independently merits this Court's review. In this case, the Sixth Circuit found that Petitioners failed to address "Social Security's contrary determination of Glenn's status." Pet. App. 12a. Yet, the only evidence before the Court or the administrator was the decision of the administrative law judge of the Social Security Administration. Pet. App. 3. Respondent did not provide the underlying testimony and exhibits of the Social Security hearing to the claim administrator.[5] Nevertheless, the Sixth Circuit overturned the ERISA administrator's benefits decision, holding that "... an ERISA plan administrator's failure to address the Social Security Administration's finding that the claimant was 'totally disabled' is yet another factor that can render the denial of further long-term disability benefits arbitrary and capricious." *Id.* at 669. In addition, the Circuit held that "MetLife obviously should have given appropriate weight to that deter-

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[5] There is no requirement that the claim administrator acquire Social Security Administration transcripts and exhibits. *Vega* v. *National Life Services*, 188 F. 3d 287, 298 (5th Cir 1999); *Donato* v. *Metropolitan Life Ins. Co.*, 19 F. 3d 375, 380 (7th Cir. 1994) (The ERISA administrator was aware of the SSA determination but did not have the underlying record. The Circuit held "...although MetLife was apprised of ...[the SSA]... determination, the Social Security file was never before MetLife in making Ms. Donato's benefits determination; and MetLife was bound only to consider what evidence and information it had before it."), *disapproved of in part by Diaz* v. *Prudential Ins. Co. of America*, 424 F. 3d 635, 638-9 (7th Cir. 2005)

mination." *Id.* at 667 This holding follows other decisions of the Sixth Circuit holding that in denying a disability claim, the ERISA administrator must specifically consider in its decision a Social Security Administration disability determination. *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 530 (6th Cir. 2003); *Calvert* v. *Firstar Fin., Inc.*, 409 F.3d 286, 294 (6th Cir. 2005).[6]

A. The Sixth Circuit's Holding that A Bare Determination By The Social Security Administrator Of Total Disability is Evidence Which Must Be Considered by An ERISA Administrator Conflicts with Decisions in Four Other Circuits.

The Sixth Circuit's approach, however, conflicts with decisions in four other circuits. Specifically, the D.C., Seventh, Eighth, and Ninth Circuits hold that a bare decision by the Social Security Administration has *no* evidentiary weight.

For example, the D.C. Circuit in *Block* v. *Pitney Bowes, Inc.* 952 F.2d 1450, 1455-6 (D.C. Cir. 1992), refused to give any weight to a bare Social Security decision. In that case, the employee argued that the Social Security Administration's award of disability benefits to him demonstrated the arbitrariness of the ERISA administrator's final decision. But the D.C. Circuit stated that "[t]he Social Security award, however, rested at least in part on medical reports never submitted to the Committee. Courts review ERISA-plan benefit decisions on the evidence presented to the plan administrators, not on a record later made in another fo-

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[6] However, another Sixth Circuit panel in a case decided after *Darland*, but before *Calvert* and before this case, relied on *Black & Decker Disability Plan v. Nord* to conclude that the rule in *Darland* is no longer viable because it relied on the "treating physician rule." *Whitaker* v. *Hartford Life & Accident Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005).

rum. . . . We therefore accord no weight to the Social Security Administration's determination." *Ibid.*

Similarly, in the Seventh Circuit case of *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994), an ERISA administrator was given a decision of total disability from the Social Security Administration. The administrator found that the employee was not disabled and did not address the Social Security Administration determination in his decision. The Seventh Circuit rejected the notion that courts must treat bare decisions by the Social Security Administrator as evidence in an ERISA disability determination: "[a]lthough MetLife was apprised of [the Social Security Administration's] contrary [disability] determination, the Social Security file was never before MetLife in making Ms. Donato's benefits determination, and MetLife was bound only to consider what evidence and information it had before it." *Ibid.* Thus, neither the administrator nor the reviewing court was required to give any weight to the SSA's decision.

The Eighth Circuit reached the same conclusion in *Conley* v. *Pitney-Bowes* 176 F.3d 1044, 1050 (8th Cir. 1999). There the court upheld a district court decision that an award of social security benefits "was not entitled to any particular weight in the overall consideration" of a disability claim." And the Eighth Circuit in fact gave that award no weight at all.

Similarly, the Ninth Circuit in *Madden* v. *ITT Long Term Disability Plan*, 914 F.2d 1279, 1285 (9th Cir. 1990), held that an ERISA administrator's failure to consider a determination of disability under the Social Security Administration was not arbitrary and capricious, where "all medical evidence submitted to [the plan administrator] and in the record" showed that the claimant was not "totally disabled" by standard employed in the plan. Again, the Ninth Circuit

did not require the administrator or the reviewing court to give any weight to the SSA's decision.

All of these decisions conflict with the Sixth Circuit's holding that a decision by the Social Security Administration, without more, is a fact that must be considered and weighed both by the administrator and the reviewing court. If the Sixth Circuit had followed the rulings of these other circuits, it could not have reversed the district court's decision on the basis of the administrator's failure to consider the SSA's finding of disability.

B. Two Other Circuits Hold, With The Court Below, that a Bare Determination by the Social Security Administration is Evidence Which the ERISA Administrator Must Consider in a Benefit Denial.

The Sixth Circuit's position is also supported by decisions in the First and Second Circuits, thereby creating a 4-3 split of authority on this issue. Specifically, the First and Second Circuits both squarely hold that a disability decision by the Social Security Administrator is evidence to be considered by the ERISA administrator.

For example, in *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 420 (1st Cir. 2000), the First Circuit held that "...a Social Security benefits decision might be relevant to an insurer's eligibility determination, [although] it should not be given controlling weight..." Similarly, in *Paese* v. *Hartford Life and Accident Ins. Co.*, 449 F.3d 435, 442 (2nd Cir. 2006), the Second Circuit held that "[t]he court acted well within its discretion when it considered the SSA's findings as some evidence of total disability, even though they were not binding on the ERISA Plan, and even though the SSA's definition of disability may differ from that in the Sequa Plan."

C. The Sixth Circuit's Holding Contravenes Congressional Goals and is Otherwise Incorrect.

Like the Sixth Circuit's holding on the effect of an insurer's dual roles, the Circuit's requirement that ERISA administrators consider and refute bare disability determinations by the Social Security Administration is also wrong for several reasons.

1. First, the Sixth Circuit's approach contravenes Congress's goals in enacting ERISA. Decisions of the Social Security Administration are based upon different statutory law, administrative procedures and evidentiary rules that do not apply to ERISA administrators. That fact was recently recognized by this Court in deciding whether the Social Security Administration's treating physician rule should be transported into ERISA cases:

> The Social Security Act creates a nationwide benefits program funded by Federal Insurance Contributions Act payments ... and superintended by the Commissioner of Social Security. To cope with the "more than 2.5 million claims for disability benefits [filed] each year," ... the Commissioner has published detailed regulations governing benefits adjudications. ...Presumptions employed in the Commissioner's regulations "grow out of the need to administer a large benefits system efficiently." ...
>
> In contrast to the obligatory, nationwide Social Security program," nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." ... Rather, employers have large leeway to design disability and other welfare plans as they see fit. ...

Black & Decker v. *Nord, supra,* 538 U.S. at 833 (2003). The Sixth Circuit's approach ignores the critical differences between these two systems.

In addition, a fiduciary, such as petitioner, owes a duty not just to the participant seeking benefits, but also to the plan as a whole. *Varity Corp* v. *Howe,* 516 U.S. 489, 513 (1996); 29 U.S. C. § 1104(a)(1)(A). Plan fiduciaries thus cannot pay all claims, because if they do, premiums or contributions will have to rise - increasing costs to all participants. ERISA was passed not only to protect the rights of beneficiaries but also to encourage employers to create and maintain voluntary benefit plans, see H.R Rep. No. 553, 93rd Cong., 2nd Sess. 1 reprinted in 1974 U.S.C.C.A.N. 4639; *Varity* v. *Howe,* 516 U.S. 489, 497 (1996) and to maintain premium cost of [the ERISA] system at a reasonable level." 29 USC. § 1001b (c)(5). Here again, the approach of the Sixth Circuit and its allies ignores this critical duty that the law imposes on plan administrators.

2. The Sixth Circuit's approach also ignores, not only "the public interest in encouraging the formation of employee benefit plans," but also "the need for prompt and fair claims settlement procedures." *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U.S. 41, 54 (1987). For example, in *Varity Corp.*, 516 U.S. at 497, the Court pointed out that courts should take into account Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans."

In this case the administrator was aware of but did not comment on the disability determination of the administrative law judge. While the underlying testimony and evidence may have been of some value, the bare decision of the administrative law judge is meaningless considering the differences in the laws, procedures and evidentiary rules between the ERISA and Social Security regimes. And requiring claim administrators to address and refute Social Security Administration decisions in such circumstances would introduce additional costs and delay.

This Court's decision in *Black & Decker* v. *Nord* rested, in part, on these very concerns. There the Court addressed the issue of whether the ERISA administrator must specifically consider in writing the opinion of the treating physician. The Court concluded that reviewing courts may not "impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker* at 834. A bare determination by the Social Security Administration has less evidentiary value than a treating physician's opinion and therefore should not require specific consideration in the ERISA administrator's written opinion.

For all of these reasons, the Sixth Circuit's decision is wrong on the merits, and should be reviewed and reversed.

D. The Present Circuit Conflict is Intolerable and Should Be Resolved in This Case.

As with the first question presented, there are compelling reasons for this Court to resolve the confusion and conflict over the proper treatment of a Social Security Administration decision.

First, such a resolution will foster and protect the uniformity that is central to the entire ERISA scheme – uniformity that is currently absent because different circuits impose different standards on ERISA administrators. Indeed, at least two circuits have issued conflicting decisions as to whether petitioner MetLife, as a claims administrator for similar plans, must afford deference to the opinions of administrative law judges of the Social Security Administration. Compare *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (in denying disability claim, MetLife was not required to accept as evidence, or explain its rejection of, SSA decision granting disability benefits) with *Glenn*, 461 F.3d 660 (6th Cir. 2006) (in denying disability

claim, MetLife abused its discretion by not considering and refuting a SSA decision granting disability benefits).

The Sears plan at issue in this case, like many other ERISA plans, is national in scope and MetLife must administer claims on a nationwide basis. Yet here too the current split of authority on the status of Social Security Administration decisions forces administrators of national plans to use different standards based upon the circuit court that has jurisdiction. This conflicts with the ERISA mandate for uniform plan administration. *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 383-84 (2002). As this Court has put it, "Uniformity is impossible ... if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001).

Second, resolution of this question will remove an unfair and intolerable burden on ERISA administrators. As noted, the decision below requires administrators to accept or refute SSA decisions without the benefit of the underlying SSA record. The decision thereby assumes that all SSA disability cases are based on the same disability, the same definition of disability, and the same medical and vocational evidence that the claimant submitted to the ERISA claim administrator. But without the benefit of the underlying testimony and evidence presented at the SSA hearing, these assumptions may prove faulty.

Indeed, in this case, the administrative law judge did not have the benefit of the treating physician's March 13, 2002 report – in which he opined that the claimant was "able to work in a sedentary physical exertion level occupation" – because the administrative law judge's hearing on the SSA claim was held on the very same day that the report was issued. And, while the ERISA administrator was aware of the administrative law judge's decision, the administrator did not know what underlying testimony or medical records were presented in the SSA case.

Third, plenary review will enable the Court to remove the intolerable and senseless inconsistency between the treatment of SSA administrators and treating physicians. In deciding SSA disability claims, administrative law judges are required to give deference to the opinions of treating physicians. However, the Court has concluded that such deference is not required of administrators deciding ERISA based claims. *Black & Decker* v. *Nord, supra,* 538 U.S. at 833 (2003). Thus in the First, Second and Sixth Circuits, in spite of the ruling of this Court, the ERISA administrator is required to specifically refute a Social Security Administration decision based solely on a treating physician's opinion even though the administrator has no obligation to refute the treating physician's opinion itself.

The additional burdens imposed upon ERISA administrators by the decision below make it much more difficult for administrators to render consistent and streamlined claims administration throughout the United States. Under the Sixth Circuit's rule, if ERISA administrators are to make accurate and effective benefits decisions, they will have to undertake the burden of acquiring the underlying SSA record. This not only increases the time it will take to make benefits decisions, but it shifts the burden from the claimant – to provide all of the relevant evidence that supports her claim – to the ERISA administrator.[7]

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[7] This inconsistency, moreover, is not required by the pertinent regulations. ERISA and its Department of Labor ("DOL") regulations were written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. Yet there are no provisions in ERISA that require an ERISA administrator to accept or reject SSA decisions. ERISA regulations are written "...to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." (Benefit Claims Procedure Regulation, Question B-4;

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Employers do not have to provide employee disability plans. One purpose of ERISA was to encourage employers to adopt such plans. The rules imposed in this case cause inconsistent decisions from ERISA administrators and will discourage employers from establishing or maintaining long-term disability plans because of the added costs of administration and risks of reversal in court.

CONCLUSION

The petition should be granted.

Respectfully submitted

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http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html)
The DOL has the authority under ERISA to adopt regulations governing the administration of benefit claims for disability plans. While the DOL, as recently as 2001, issued numerous new and revised ERISA regulations, it has never required ERISA administrators to adopt, or explain their rejection of SSA decisions.

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 05-3918

WANDA GLENN,
Plaintiff-Appellant,

v.

METLIFE (Metropolitan Life Insurance Company) and LONG TERM DISABILITY PLAN for Associates of Sears, Roebuck and Company,
Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Ohio at Columbus.
No. 03-00572—George C. Smith, District Judge.

Argued: April 28, 2006
Decided and Filed: September 1, 2006

Before: KEITH, MERRITT, and DAUGHTREY, *Circuit Judges*.

COUNSEL

ARGUED: Stanley L. Myers, Columbus, Ohio, for Appellant. C. Scott Lanz, MANCHESTER, BENNETT, POWERS & ULLMAN, Youngstown, Ohio, for Appellee. ON BRIEF: Stanley L. Myers, Columbus, Ohio, for Appellant. C. Scott Lanz, MANCHESTER, BENNETT, POWERS & ULLMAN, Youngstown, Ohio, for Appellee.

DAUGHTREY, J., delivered the opinion of the court, in which KEITH, J., joined. MERRITT, J. (p. 14), delivered a separate opinion concurring in the reversal of the judgment below but changing the instructions on remand.

OPINION

MARTHA CRAIG DAUGHTREY, *Circuit Judge*. The plaintiff, Wanda Glenn, filed this ERISA action against defendant Metropolitan Life Insurance Co., the plan administrator for Sears, Roebuck and Co., after MetLife terminated the long-term disability benefits that Glenn had been receiving as a former Sears employee, on the ground that her condition had improved to the point that she was no longer "totally disabled." The district court upheld MetLife's determination, finding that the decision was not arbitrary and capricious, and granted summary judgment to the defendants.

For the reasons set out below, we conclude that the record does not support the conclusion that MetLife's denial of Glenn's claim was the result of a deliberative process or that it was based on substantial evidence. We therefore reverse the judgment of the district court and remand the case for further proceedings.

FACTUAL AND PROCEDURAL BACKGROUND

The plaintiff, Wanda Glenn, worked for Sears, Roebuck from 1986 until April 29, 2000, at which point she took a medical leave of absence and has not since returned to work. Glenn's final position with Sears was as sales manager in the women's department, which entailed a workweek of 40-50 hours per week and the training and direct supervision of 20-30 sales associates. The description of her job, prepared by Sears, indicated that the job required sitting up to 20 percent of the workday, standing for 20-60 percent of the workday, and some climbing, reaching, stooping, and lifting. Glenn was responsible for supervising other employees, ensuring that her department was properly stocked with merchandise, satisfy-

ing the needs and demands of customers, and identifying and solving various problems as they arose. She reported to the store's general manager.

Glenn submitted a disability claim under Sears's long-term disability plan on June 20, 2000, attaching a letter from her treating physician, Dr. Rajendera C. Patel, dated April 30, 2000, indicating that Glenn had been diagnosed with "severe dilated cardiomyopathy," a disease of the heart muscle that causes the heart to become enlarged and, for that reason, to pump inadequately. Her symptoms included general fatigue and shortness of breath on exertion. Dr. Patel further stated, "From my standpoint, this patient cannot return to any kind of job that would require any significant physical or psychological stress."

The Sears disability plan for which Glenn applied covered two distinct stages of "total disability." The first provided that a participant was totally disabled when she was "completely and continuously unable to perform each of the material duties of [her] regular job." The second category became relevant after the first 24 months of benefits and required that the participant be "completely and continuously unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning." (Emphasis added.) Glenn's claim was approved, and she began receiving long-term disability benefits following the completion of the 140-day elimination period mandated in the plan.

Two months later, in August 2000, Glenn filed for Social Security disability benefits at the direction of plan administrators, who steered Glenn to Kennedy & Associates, a law firm specializing in obtaining such benefits. The Social Security Administration initially denied Glenn's claim, but an administrative law judge eventually issued a decision finding that Glenn was totally disabled as of April 30, 2000, and was entitled to benefits retroactive to October 2000. As a result,

MetLife demanded reimbursement for its overpayment of benefits, based on the amount of Glenn's newly awarded Social Security benefits, and collected $13,502.50 from her.

On May 20, 2003, MetLife sent a letter advising Glenn that if she wished to continue receiving long-term disability benefits, she was required to demonstrate that she met the second definition for total disability, *i.e.*, that she was "incapable of performing the material duties of any gainful occupation as defined by the plan." The letter further advised that, in making a claim determination, MetLife would review "[Glenn]'s vocational information, medical information and [Glenn]'s specific restrictions and limitations that are supported by objective medical evidence."

Glenn's medical information was provided largely by Dr. Patel, the cardiologist who oversaw Glenn's care both before and during the period relevant to this appeal. The record indicates that Glenn had developed hypertension in the early 1980s and had been treated with anti-hypertension therapy since at least 1985. In 1989, she experienced "sudden cardiac death" but was resuscitated and implanted with a defibrillator system. Diagnosed with left ventricular dysfunction, Glenn was hospitalized twice again in the 1990s, once before and once after she began work at Sears. In 2000, she began experiencing prolonged chest tightness, shortness of breath, "increasing fatigue by the end of the day," and edema in her legs from "prolonged standing at work." Because of her progressive ventricular dysfunction, at one point Dr. Patel referred Glenn to Dr. Carl Leier at Ohio State University Hospital to consider the possibility of a heart transplant. In March 2000, Dr. Patel ordered an angiogram, from which he diagnosed Glenn with severe dilated cardiomyopathy. In a letter dated April 7, 2000, Dr. Patel indicated that his patient's "main problem now is stress at work. She works in a Sears store and does have physical as well as psychological stress. Considering her low ejection fraction, I feel that she

may not be able to continue to work in any kind of environment that would cause any significant physical or psychological stress and demands." Glenn took medical leave from Sears at the end of that month.

Glenn underwent significant treatment during the next several months, taking as many as seven or eight prescription medications for her heart condition. Dr. Patel noted that, almost three months after ceasing to work at Sears, Glenn was "doing clinically well." He observed that "some of her improvement is from the reduction of stress and strain of work. She still has good and bad days and in fact there are periods where she feels extremely tired and fatigued and runs out of steam." In November 2000, however, Dr. Patel notified MetLife that Glenn was totally disabled from undertaking any occupation and that he did not expect her to be able to return to work.

In March 2001, Glenn underwent a further evaluation of her cardiomyopathy that found her ejection fraction found to be "mildly reduced" and reported "some improvement in her LV [left ventricular] function." Through a walking regime, Glenn had been able to increase her "exercise tolerance," but Dr. Patel noted that she "still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress." Dr Patel also reported, "From overall evaluation, Wanda seems to be clinically stable and I have advised her to continue her current regimen including Lasix, potassium, Lanoxim, Norvasc, aspirin, calcium, Normodyne and Diovan." In March 2002, a year later, when Dr. Patel filled out a MetLife long-term benefits evaluation form, he indicated that Glenn could lift and carry up to 20 pounds occasionally, had the ability to perform bilateral repetitive foot and hand movements, and could sit eight hours of the day, stand four, and walk two. He also checked "yes" when asked on the form whether she was "able to work in a sedentary physical exertion level occupation." Although the

evaluation form was intended to assess capacity for full-time work, Dr. Patel signed it without indicating whether he was releasing Glenn to return to work or what restrictions might apply if she did go back to work. In a later evaluation, Dr. Patel's answers were consistent with his earlier responses, except that he added, "No emotional stress/No heavy exertion." Dr. Patel filled out that form on June 12, 2002.

However, just six days later, Dr. Patel sent a progress report to Glenn's internist indicating that Glenn "was back in our office earlier than expected," complaining of fatigue, "shortness of breath on moderate exertion," and "significant anxiety . . . regarding the disability and having to return to work." Dr. Patel concluded, "From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability" rather than returning to her job. Dr. Patel reiterated his opinion that Glenn should not return to work in a letter dated July 22, 2002:

> [Glenn] has dilated cardiomyopathy as well as a history of ventricular tachycardia requiring an implantable defibrillator device. The patient has been on multiple medications for her dilated cardiomyopathy. The patient continues to have significant difficulty with exertional shortness of breath on any kind of moderate exertion. She also continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition and she decompensates fast. This has happened on multiple occasions in the past. The patient has tried to return to work in the past with exacerbation of her symptoms as well as exacerbation of her condition.
>
> At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and

> symp-tomology. The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

On August 28, 2002, MetLife notified Glenn that her long-term benefits would be terminated on September 16, 2002, based on the administrative decision that "[t]here is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work-related stress." The notice concluded that "records submitted for review do not support cardiovascular impairment that would prevent you from performing full time sedentary work" and pointed primarily to medical information showing that Dr. Patel had found her to be "clinically stable" with "a better exercise tolerance" on November 2, 2001, and — based on a check mark on MetLife's evaluation form — able to return to work on March 13, 2002. MetLife's letter did not address Dr. Patel's letter of July 22, 2002, in which he stated that Glenn should not return to work.

Glenn appealed the denial of disability benefits. While the appeal was pending, Dr. Patel submitted a letter dated February 12, 2003, in which he reiterated his opinion that Glenn could not return to work:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomology, there was never a time where I felt that this patient would be able to return to full-time employment. I strongly believe that employment would put significant stress on her overall system, and she may decompensate. Ms. Glenn does not have any emotional condition that causes her cardiac problem. She has a cardiac problem that is exacerbated by any kind of stress.
>
> My position is that she should be considered completely disabled, mainly from her cardiomyopathy and associated symptoms from her LV dysfunction.

In response, MetLife referred the case to an Independent Physician's Consultant Board. There, Dr. Chandrakant Pujara reviewed Glenn's medical records and offered an opinion based on a review of Glenn's file. In a letter dated May 2, 2003, he noted that Glenn's "ejection fraction indeed has improved with medical therapy and probably with biventricular pacing as well" but concluded that Glenn was unable to do any "exertional physical activity." Dr. Pujara's prognosis was, at best, ambiguous:

> The actual impact of any form of real or perceived emotional stress on cardiac arrhythmias, or cardiomyopathy is difficult to gauge in an individual patient. However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

Despite the equivocal nature of this report, MetLife issued a final denial of disability benefits to Glenn on May 20, 2003. The notice of denial relied on the same information as in the prior termination notice, notably Dr. Patel's June 2002 evaluation form, as well as Dr. Pujara's assessment. Although MetLife acknowledged Dr. Patel's letter of February 2003, in which he clarified his position regarding Glenn's ability to return to work, MetLife concluded that "documentation on file does not support a disability that would prevent Ms. Glenn from performing any occupation, as defined in the plan." As before, however, no mention was made of Dr. Patel's July 2002 letter, in which he rendered essentially the same opinion as in his letter of February 12, 2003.

Having exhausted her administrative remedies under the plan, Glenn brought a civil action pursuant to Section 502(a) of the Employee Retirement Income Security Act of 1974, as

amended, 29 U.S.C. § 1132 (ERISA). The district court denied her motion for judgment on the administrative record and, instead, granted MetLife's cross-motion. This appeal followed.

DISCUSSION

A. Standard of Review

We review *de novo* the decision of a district court granting judgment in an ERISA disability benefit action based on an administrative record, *see Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 613 (6th Cir. 1998), and apply the same legal standard as did the district court. *See id.*; *Whitaker v. Hartford Life & Accident Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005). In this case, the district court appropriately reviewed the record under the "arbitrary and capricious" standard, because the plan at issue granted the plan administrator discretionary authority to interpret the terms of the plan and to determine benefits. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111- 15 (1989); *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 168 (6th Cir. 2003). Indeed, the plaintiff conceded that review for arbitrariness was the correct standard of review here.

Under that standard, we will uphold the administrator's decision "if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Baker v. United Mine Workers of Am. Health & Ret. Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991). Despite this deferential standard, however, our review is no mere formality. "The arbitrary-and-capricious standard . . . does not require us merely to rubber stamp the administrator's decision." *Jones v. Metro. Life Ins. Co.*, 385 F.3d 654, 661 (6th Cir. 2004) (citation omitted). Instead, we are required to review "the quality and quantity of the medical evidence and the opinions on both sides of the issues." *McDonald*, 347 F.3d at 172.

Moreover, as discussed below, we are entitled to take into account the existence of a conflict of interest that results when, as in this case, the plan administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits and to factor in the plan administrator's failure to give consideration to the Social Security Administration's determination that Glenn was totally disabled.

B. Conflict of Interest

In the instant case, MetLife is authorized both to decide whether an employee is eligible for benefits and to pay those benefits. This dual function creates an apparent conflict of interest. *See Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled on other grounds by Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) (holding that plan administrators do not owe special deference to the opinion of a treating physician). In discussing the applicable standard of review, the district court identified this conflict of interest as a relevant factor in determining whether an abuse of discretion had taken place. *See Glenn v. Metropolitan Life Ins. Co.*, 2005 WL 1364625 at *4 (S.D. Ohio, June 8, 2005) (citing *Firestone Tire & Rubber*, 489 U.S. at 115 ("[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'") (internal citation omitted)). However, the court's analysis of the plan administrator's basis for terminating benefits does not include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight. It appears to us, as a result, that this factor did not receive appropriate consideration by the district court.

C. Social Security Disability Determination

There is yet another factor that the district court appears to have given inadequate consideration. The plaintiff contends

that the plan administrator was arbitrary in failing to consider the award of disability benefits that she secured from the Social Security Administration. The record reflects that MetLife notified her that payments for long-term disability were subject to a discount for amounts received from other sources and steered her to a law firm specializing in securing disability benefits from the Social Security Administration. After the firm secured an award of benefits for her based on a claim of total disability, MetLife deducted the amount of those government benefits from the disability payments that it was obliged to pay and demanded a refund from Glenn in the amount of $13,500. And, yet, in making the decision to terminate payments under the MetLife policy, the plan administrator gave no weight whatever to the Social Security Administration's determination of total disability. Hence, Glenn posits that MetLife took blatantly inconsistent positions — relying on the finding by the Social Security administrative law judge that she was totally disabled but contending that she was capable of performing sedentary work in denying her ERISA benefits.

The district court recognized this inconsistency but declined to invoke the doctrine of estoppel. Although we conclude that this ruling was technically correct, the fact that MetLife and the Social Security Administration reached contrary conclusions regarding Glenn's disability status has two ramifications for this appeal. The first stems from the fact that MetLife assisted Glenn in obtaining Social Security benefits and reaped a financial benefit of its own when that assistance was successful. The second issue relates to the fact that, in denying Glenn continuation of her long-term benefits, MetLife failed to address Social Security's contrary determination of Glenn's status. It is obvious that both factors are relevant in determining whether MetLife's decision was arbitrary and capricious.

The courts have recognized that a disability determination by the Social Security Administration is relevant in an action to determine the arbitrariness of a decision to terminate benefits under an ERISA plan. In *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998), for example, the Seventh Circuit overturned a plan administrator's denial of disability benefits after finding that the insurance company had encouraged and assisted the plaintiff in applying for Social Security benefits, which were granted after an administrative law judge found that the plaintiff was totally disabled. Writing for the court, Judge Posner noted that the concept of judicial estoppel was not technically applicable but, nevertheless, he concluded that the inconsistency in litigation positions had to be factored into a review of the plan administrator's determination for arbitrariness:

> The grant of social security disability benefits . . . brings the case within the penumbra of the doctrine of judicial estoppel — that if a party wins a suit on one ground, it can't turn around and in further litigation with the same opponent repudiate the ground in order to win a further victory. The doctrine is technically not applicable here, because MetLife and ITT, the defendants in this suit, were not parties to the proceeding before the Social Security Administration. Yet they "prevailed" there in a practical sense because the grant of social security benefits to Ladd reduced the amount of her claim against the employee welfare plan. If we reflect on the purpose of the doctrine, which is to reduce fraud in the legal process by forcing a modicum of consistency on a repeating litigant, we see that its spirit is applicable here. To lighten the cost to the employee welfare plan of Ladd's disability, the defendants encouraged and supported her effort to demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation. To further lighten that cost, it then turned around and denied that Ladd was totally disabled,

> even though her condition had meanwhile deteriorated. In effect, having won once the defendants repudiated the basis of their first victory in order to win a second victory. This sequence casts additional doubt on the adequacy of their evaluation of Ladd's claim, even if it does not provide an independent basis for rejecting that evaluation.

Id. at 756 (citations omitted).

We adopted the Seventh Circuit's "penumbra" rationale in *Darland v. Fortis Benefits Insurance Co.*, a case in which the ERISA plan administrator had, as here, "requested that Darland apply for Social Security disability benefits so as to reduce the amount of monthly disability payments that it paid Darland under the plan" and then demanded reimbursement for overpayment of insurance benefits at the same time it sought to terminate Darland's benefits on the ground that he was no longer disabled. *Darland*, 317 F.3d at 530. We concluded that "a plan administrator's decision denying disability benefits where the Social Security Administration has determined that the applicant was totally disabled" can be considered arbitrary and capricious, *id.* at 529, especially where "it is plainly evident that the Social Security standard for a disability determination is much more stringent than that required by [the defendant's] insurance policy." *Id.* at 530. The latter observation not only pertains in this case to the language of the policy[1] but is all the more relevant in the

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[1] After 24 months, the plan awards disability benefits to an individual who is "completely and continuously unable to perform the duties of any gainful work or service for which he is reasonably qualified, taking into consideration his training, education, experience, and past earning." Social Security disability insurance benefits are awarded only if the individual's impairment is of such severity that he "cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives." 42 U.S.C. § 423(d)(2)(A). The Social Security determination does not take into

wake of the Supreme Court's subsequent ruling that the special deference extended to the opinion of a treating physician in a Social Security dispute is not applicable in ERISA cases. *See Black & Decker Disability Plan*, 538 U.S. at 833-34.

The district court in this case recognized that MetLife had encouraged and assisted Wanda Glenn in obtaining Social Security disability benefits, just as MetLife had in *Ladd*, but found Glenn's case to be distinguishable in two respects. First, the district court noted, correctly, that the record before the administrative law judge did not include the report, signed on the same day that the administrative judge's decision was made, in which Dr. Patel answered "yes" to MetLife's question, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" However, the relative significance of this omission in the record is undercut by the existence of Dr. Patel's subsequent clarification of July 22, 2002, in which he indicated that he had never considered his patient capable of resuming full-time work, and by the fact that there is no indication in the record that Glenn's government benefits have ever been discontinued. Second, the district court found, incorrectly, that it was unclear whether or not MetLife had actually benefitted from the plaintiff's receipt of Social Security benefits. We find it abundantly clear on the record that Glenn reimbursed MetLife for overpayment of benefits, based on her receipt of Social Security benefits.

Having benefitted financially from the government's determination that Glenn was totally disabled, MetLife obviously should have given appropriate weight to that determination. As we held in *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 295 (6th Cir. 2005), a case with several parallels to this one, an ERISA plan administrator's failure to address the Social

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account past earning or location of the applicant.

Security Administration's finding that the claimant was "totally disabled" is yet another factor that can render the denial of further long-term disability benefits arbitrary and capricious. In *Calvert*, as here, the plan administrator relied almost exclusively on the recommendation of a physician, hired by the administrator, who conducted a file review but not a physical examination of the claimant. *See id.* We held that such a review was clearly inadequate, given that in reaching the determination to deny benefits, the plan administrator not only overlooked surgical reports, X-rays, and CT scans that documented the claimant's disability, but also failed to mention the Social Security Administration's determination, "not . . . even to discount or disagree with it, which indicates that he may not even have been aware of it." *Id.* at 296.

Here, there is no possibility that the plan administrator failed to discuss the Social Security award for lack of awareness. And, "the S[ocial] S[ecurity] A[dministration] determination, though certainly not binding, is far from meaningless." *Id.* at 294. That MetLife apparently failed to consider the Social Security Administration's finding of disability in reaching its own determination of disability does not render the decision arbitrary *per se*, but it is obviously a significant factor to be considered upon review.

D. The Medical Evidence

Even more perplexing than the plan administrator's failure to consider the award of Social Security benefits is the persistent failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe Glenn was capable of returning to work, sedentary or otherwise. This omission stands in stark contrast to the heavy reliance MetLife placed in its brief on the "physical capacity assessment" form that MetLife provided to Dr. Patel and that he filled in and signed on March 13, 2002. On the form, Dr. Patel indicated that his patient could sit for eight hours a day, stand for four hours, and walk

for two hours. He also checked yes when asked, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" That information is so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational.

Nevertheless, MetLife cannot be faulted for its initial reliance on the opinion that Glenn could "work at a sedentary physical exertion level occupation" in consulting a "transferable skills analyst," who then compiled a list of clerical jobs (account information clerk, attendance clerk, classified ad clerk) that would be available to someone with the physical limitations listed on the physical assessment form. There is no indication in the record, however, that the transferable skills analyst considered the medical evidence in the record or Dr. Patel's reasons for concluding that his patient should not return to full-time work of any kind. Nevertheless, the plan administrator, relying only on the vocational assessment, the information on the MetLife form supplied by Dr. Patel on March 13, 2002, and certain other technical information that seems to have been almost randomly selected from his reports (one paragraph reads in its entirety, without further explanation: "Your June 18, 2002 examination showed an ejection fraction of 35 to 40%."), declined to grant further long-term benefits in a letter dated August 28, 2002. Nowhere in the notice of denial does the plan administrator mention the decision of the Social Security Administration finding that Glenn was totally disabled.

Perhaps most curious is the plan administrator's treatment of Dr. Patel's then-most recent assessments of his patient's condition. The plan administrator emphasized the content of yet another "physical capacities evaluation" dated June 12, 2002, that indicated by check-off information consistent with that on the March 13 form ("sit for eight hours, stand for four hours, walk for 2 to 4 hours," etc.). But the June 12 form does

not recommend that Glenn return to work, nor does it release her to return to work. Furthermore, the notice from the plan administrator made no mention whatever of the letter Dr. Patel sent on July 22, 2002, which, as described above, noted that Glenn "continues to have significant difficulty with exertional shortness of breath on any kind of moderate exertion" and "significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition and she decompensates fast." Dr. Patel concluded:

> At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and symptomatololgy. The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

This letter to MetLife is consistent with a follow-up report a month earlier that Dr. Patel sent to Glenn's internist, Dr. Rhee, in which he concluded: "From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability."

Based on Dr. Patel's assessment of her condition, Glenn appealed MetLife's decision to terminate her benefits, and the decision was reviewed internally by MetLife. In a letter dated May 20, 2003, the plan administrator once again denied benefits, this time based on the evaluation form signed by Dr. Patel in June 2002, the transferable skills analysis from July 2002, and two items that had not been part of the earlier review: a letter from Dr. Patel dated February 12, 2003, and the report from the outside consultant, Dr. Pujara, dated May 2, 2003. Once again, there is no mention of Dr. Patel's July 2002 letter stating unequivocally that his patient was not able to return to work.

The appeal decision does indicate that Dr. Patel's letter "noted that his previous reports indicated that Ms Glenn was fit for sedentary work" but that "based on her clinical condition and symptomatology, Dr. Patel never felt that Ms. Glenn could return to full-time employment" and that she "should be considered completely disabled from her cardiomyopathy and associated symptoms from her LV dysfunction." On the other hand, there is no explanation in the notice for the failure to give any weight to this report.

The summary of Dr. Pujara's report reiterated the information that he found in the medical files submitted by MetLife — Dr. Pujara did not conduct an examination of Glenn but merely undertook a file review — and concluded: "The consultant noted that based on the medical information Ms. Glenn has achieved a relatively stable cardiac status." What the summary omits is any indication that the consultant thought that she could return to work. In fact, Dr. Pujara noted that given the information in her file, "the patient certainly is not able to do any exertional physical activity" and, with regard to the possibility of "sedentary activity," concluded that "[i]f the job environment entails a significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered." Although it appears that MetLife forwarded the June 2002 evaluation form to Dr. Pujara, there is no indication that he was provided with copies of Dr. Patel's letters of July 2002 and February 2003, in which Dr. Patel concluded that Glenn was not able to undertake sedentary work because any degree of stress caused her medical condition to "decompensate."[2]

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[2] At oral argument of this case, the defendants conceded that Glenn had not been offered a part-time position at Sears and that she would have no chance of receiving benefits under the Sears ERISA plan if she went to work at for another employer on the trial basis that Dr. Pujara suggested.

The Plan provides that "[w]hile a claim is pending, we, at our expense, have the right to have you examined by doctors of our choice when and as often as we reasonably choose." MetLife instead opted to have a file review, a decision that does not render its denial of benefits arbitrary *per se*. However, it is yet another factor to be considered in the overall assessment of its decision-making process. *See Calvert*, 409 F.3d at 295. Moreover, as noted above, it appears that the physician charged with conducting the independent file review was not provided with Dr. Patel's letters of July 2002 and February 2003.

As a result, Dr. Patel is the only physician to have personally treated and observed Glenn over the entire course of her dispute with MetLife. As noted above, the plan administrator need not accord special deference to the opinion of a treating physician. By the same token, it may not arbitrarily repudiate or refuse to consider the opinions of a treating physician. *See Black & Decker Disability Plan*, 538 U.S. at 834. In its final rejection of Glenn's claim, however, MetLife did not indicate that it had considered Dr. Patel's letter of February 12, 2003, nor did it provide a reason for rejecting it.[3] It also did not indicate whether or not it had considered Dr. Patel's letter of July 22, 2002, which was consistent with the February 12 letter advising that Glenn could not return to work.

In the absence of an explanation from MetLife, the district court provided its own, noting that because Dr. Patel "expressly acknowledged that he had stated that plaintiff was fit for sedentary work . . . MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism." In support of this conclusion, the district court invoked *United States v. Willis*, 257 F.3d 636, 645-46 (6th Cir. 2001), for the proposi-

[3] MetLife maintains in its brief on appeal that the denial notice "specifically discussed" Dr. Patel's letter of February 12, 2003, we find that the word "discussed" is somewhat misleading; "mentioned" would be a more accurate choice.

tion that affidavits recanting trial testimony are viewed with "extreme suspicion." The court's reliance on *Willis* is misplaced, however, because that case addresses the full recantation of a witness's testimony in a criminal trial, a situation which is hardly equivalent to Dr. Patel's follow-up letters, which were consistent with his earlier assessments of Glenn's ability to work and which are more aptly described as clarifications, rather than recantations. Indeed, the concept of recantation has little application outside the unique context of the criminal case, and any presumption regarding the credibility of inconsistent testimony should be limited to that context.

We conclude that the only fair inference from the record would actually undercut Dr. Patel's check-offs and his brief assessment on the functional capacity form dated March 13, 2002, because that information was in direct conflict both with his earlier assessments and with every detailed written explanation that he gave concerning Glenn's disability.[4] Clearly, the plan administrator rejected Dr. Patel's more detailed reports while crediting the check-off forms. However, MetLife offered no explanation for its resolution of the conflict or, for that matter, whether it was given any consideration at all. The omission is critical, because the failure to consider evidence that is offered after an initial denial of benefits renders a final denial of benefits arbitrary and

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[4] This case is not the first in which we have been called upon to review MetLife's over-reliance on an aberrational report from a physician. In *Spangler v. Lockheed Martin Energy Systems, Inc.*, a case with several interesting parallels to this one, the plan administrator denied benefits based on the responses of the plaintiff's treating physician on the same form that Dr. Patel filled out in this case, a physical capacities evaluation that we described as "somewhat aberrant," given that "all of [the physician's] prior reports and statements clearly indicate[d] that Spangler [was] not able to perform any work." 313 F.3d 356, 362 (6th Cir. 2002). We concluded that "MetLife, as Spangler contends, 'cherry-picked' her file in hopes of obtaining a favorable report from the vocational consultant as to Spangler's ability to work." *Id*

capricious. *See Williams v. Intl Paper Co.*, 227 F.3d 706, 712-14 (6th Cir. 2000). As for the district court's attempt to reconcile the conflicts in the record, we point out that the court's role is to review the basis for the decision that was actually made by the plan administrator, not to provide an adequate basis where none was offered.

The importance of a resolution of the apparent conflict between Dr. Patel's responses on the check-off form and his later reports is even more pronounced given that Dr. Patel consistently deemed psychological stress to be a critical factor in Glenn's treatment and the deciding factor in assessing her ability to return to work. On April 7, 2000, Dr. Patel wrote that Glenn's "main problem now is stress at work." On April 30, 2000, he concluded that Glenn "cannot return to any kind of job that would require any significant physical or psychological stress." On July 29, 2000, after Glenn had been on leave from work for approximately three months, Dr. Patel observed that "some of her improvement is from the reduction of stress and strain of work." On June 12, 2002, Dr. Patel also indicated that Glenn's functional limits included "no emotional stress." The law firm retained by MetLife to represent Glenn before the Social Security Administration certainly relied on Dr. Patel's analysis of the impact of stress on Glenn's condition, even if MetLife did not. Contending before the administrative law judge assigned to her claim that "[i]n addition to findings of impaired myocardial function, Dr. Patel indicated that the severity of Ms. Glenn's symptoms and physical condition were aggravated by emotional stress," the firm pointed out that "this opinion was rendered by a longtime treating source who had referred the claimant for implantation of a new cardiac device, referred the claimant for transplantation assessment, and provided consistent care while the claimant's left ventricular functioning deteriorated."

Despite the consistent and repeated references by Dr. Patel to stress as a factor in Glenn's condition, MetLife concluded

in its final denial of benefits to Glenn, "There is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to the subjective complaints of work-related stress." But, this conclusion unjustifiably implies that Dr. Patel's observations and notations regarding stress do not constitute "supportive medical documentation." Although it is not clear from the record what sort of documentation MetLife would have found sufficient to establish the negative effect of stress on Glenn's medical condition, the plan itself does not restrict the type of evidence that may be used to demonstrate total disability. Rather, the plan provides that "[t]o qualify for benefits under the Plan, Total Disability must be supported by current medical documentation" and the claimant "must be under the regular care of a qualified physician under a course of treatment appropriate for the disability." We conclude that the plan administrator's rejection of Dr. Patel's assessment, under the standard set out in the plan, was, in fact, arbitrary.

That conclusion is supported by our decisions in similar ERISA cases. In *Evans v. UnumProvident Corp.*, 434 F.3d 866 (6th Cir. 2006), for example, a claimant applied for long-term disability benefits on the basis that her frequent seizures rendered her incapable of work. Her treating physician opined that the stress associated with her administrative duties was responsible for the severity and frequency of the episodes. *See id.* at 870. While on medical leave, the claimant saw an improvement in her condition. Her treating physician determined that it would be in the claimant's best interest not to return to work. *See id.* at 871. The insurer denied the claim, finding it unreasonable to speculate that a return to work would exacerbate the claimant's condition. *See id.* In reaching this decision, the insurer relied heavily on an independent physician's review, which declared that the impact of stress on the patient's condition was entirely self-reported and had not been corroborated by medical studies. *See id.* at 875. We found that the insurer's decision was arbitrary and capricious.

"[D]espite the unwavering expert medical opinion of plaintiff's treating physician . . . that stress is probably the most important seizure-provoking factor in all patients, and not just plaintiff, and that plaintiff's high-stress position would exacerbate her condition, defendant nonetheless unreasonably discounted stress as merely a 'prophylactic' factor that should be accorded minimal, if any, weight in its determination of disability." *Id.* at 879.

In the present case, although Dr. Patel's opinion of Glenn's ability to perform sedentary work has not been consistently expressed, he likewise has been "unwavering" in his opinion that stress is an important factor in her condition. As in Evans, the plan in this case does not say that prophylactic determinations are not relevant to the decision, nor does it say that self-reported or "subjective" factors should be accorded less significance than other indicators. And, although it is not clear that stress is *the* most important factor in all cases of cardiomyopathy, as it apparently is with epilepsy, it is unreasonable for MetLife to have dismissed stress as an improperly documented, subjective, and irrelevant factor in its disability determination.

MetLife cites *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003), as justification for discrediting Dr. Patel's opinion that Glenn was not capable even of sedentary employment. In reviewing a benefits determination in a black lung case, the *Eastover Mining* court observed that "treating physicians may have strong pro-claimant biases and lack the expertise held by non-treating doctors." *Id.* at 510 (citing *Black & Decker Disability Plan*, 538 U.S. at 832). It is true that treating physicians, "in a close case, may favor a finding of 'disabled'," 538 U.S. at 832, and that a presumption of deference to treating physicians makes little sense when "the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks." *Id.*

Moreover, although *Black & Decker Disability Plan* makes clear that MetLife bears no heightened burden of explanation when making a disability determination that runs contrary to a treating physician's opinion, *see* 538 U.S. at 831, MetLife's decision with respect to Glenn's claim does not appear to be the result of a principled reasoning process, given that Dr. Patel had expertise in treating Glenn's disability and had a longterm relationship with her.

Finally, we note that a claimant's potential ability to "return to work under certain limited circumstances," *McDonald*, 347 F.3d at 170, should not be taken to satisfy the requirements of the Sears ERISA plan when those circumstances are, as here, very limited and would not permit Wanda Glenn, pursuant to the language of the plan, to perform the duties of gainful work for which she is reasonably qualified, "taking into consideration her training, education, experience, and past earning." As we observed in *McDonald*:

> The mere possibility that a participant in an ERISA plan might be able to return to some type of gainful employment, in light of overwhelming evidence to the contrary, is an insufficient basis upon which to support a plan administrator's decision to deny that participant's claim for [long-term disability] benefits.

Id. at 170-71.

CONCLUSION

Even when it is reviewed under the highly deferential standard applicable in this case, we conclude that the plan administrator's determination to deny benefits to Glenn cannot be sustained.

> [The] obligation under ERISA to review the administrative record in order to determine whether the plan administrator acted arbitrarily and capriciously in making ERISA benefits determinations . . . inherently includes

> some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan [administrator] was able to find a single piece of evidence — no matter how obscure or untrustworthy — to support a denial of a claim for ERISA benefits.

McDonald, 347 F.3d at 172.

For the reasons set out above, we conclude that MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process. MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration. In denying benefits, it offered no explanation for crediting a brief form filled out by Dr. Patel while overlooking his detailed reports. This inappropriately selective consideration of Glenn's medical record was compounded by the fact that the occupational skills analyst and the independent medical consultant were apparently not provided with full information from Dr. Patel on which to base their conclusions. Moreover, there was no adequate basis for the plan administrator's decision not to factor in one of the major considerations in Glenn's pathology, that of the role that stress played in aggravating her condition and, in the language of the MetLife policy, in preventing her return to "gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning." Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious.

We therefore REVERSE the judgment of the district court and REMAND the case with directions to reinstate Glenn's long-term disability benefits, retroactive to the date on which

they were terminated,[5] and for such other relief as the district court finds appropriate in view of our ruling in this case.

CONCURRENCE

MERRITT, *Circuit Judge*, concurring in the reversal of the judgment below but changing the instructions on remand. A doctor reviewing Glenn's medical records on behalf of MetLife noted that Glenn "seems to be a reasonable candidate to try one of the sedentary job classes [previously suggested by MetLife] at least on a trial basis." The contract for long-term benefits expressly provides for an arrangement called "rehabilitative employment" allowing individuals like Glenn to work on a trial basis without forfeiting their benefits. At this late point, it is unclear whether rehabilitative employment is still available under the terms of the plan. What is clear, however, is that the parties should have pursued this reasonable approach earlier. Doing so would have enabled Glenn to return to work so long as her health permitted and would have reduced MetLife's payments to Glenn. I would remand the case to the district court for a hearing in which the rehabilitative employment option is explored. Otherwise, I concur in the majority opinion.

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[5] *See Kalish v. Liberty Mutual / Liberty Life Assurance Co.*, 419 F.3d 501 (6th Cir. 2005) (remanding for retroactive reinstatement of benefits where plan administrator arbitrarily and capriciously refused to consider evidence of claimant's depression as factor in disability); *Williams v. Intl Paper Co.*, 227 F.3d 706 (6th Cir. 2000) (remanding for retroactive reinstatement of benefits where plan administrator had opportunity to review all evidence and did so in a manner that was arbitrary and capricious).

APPENDIX B

UNITED STATES DISTRIICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

[Filed June 8, 2005]

Case No. 2:2003cv0572

WANDA GLENN,

Plaintiff,

v.

METROPOLITAN LIFE INSURANCE COMPANY, *et al.*,

Defendants.

JUDGE SMITH
Magistrate Judge Abel

OPINION AND ORDER

Plaintiff seeks, *inter alia*, reinstatement of long term disability ("LTD") benefits under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1132 ("ERISA"). Both sides move for entry of judgment on the administrative record (Doc. 9 and Doc. 10). For the reasons that follow, the Court orders the entry of judgment in favor of defendants and against plaintiff.

I. Facts

Plaintiff is an individual citizen of the State of Ohio. She is a participant in the subject Sears, Roebuck and Co. ("Sears") Group Long-Term Disability Plan ("Plan"). Defendant Metropolitan Life Insurance Company ("MetLife") is the

Plan fiduciary, and makes decisions regarding claims for Plan benefits. MetLife both reviews and pays claims for benefits under the Plan. Sears is the Plan sponsor and administrator.

The Plan contains two definitions for the term "totally disabled." The first applies to the initial determination of disability, and provides that a participant is totally disabled when she is "completely and continuously unable to perform each of the material duties of [her] regular job." AR 14. The second definition becomes applicable after the first twenty-four months of benefit payments, and additionally requires that the participant be "completely and continuously unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earnings." *Id.* (emphasis added).

Plaintiff worked for Sears as a sales manager in the women's department from 1994 until she became disabled. AR 153. Plaintiff was responsible for supervising other employees, ensuring that her department was properly stocked with merchandise, satisfying the needs and demands of customers, and problem identification and solution. AR 174-176. Plaintiff's responsibilities included direct supervision of twenty to thirty sales associates. AR 170.

Plaintiff worked forty to fifty hours per week before she became disabled. *Id.* Plaintiff s job at Sears required sitting 1-19% of the workday, standing 20-60% of the workday, and walking 61-100% of the workday. Her job also included some climbing, reaching, stooping, and lifting. *Id.*

Plaintiff stopped working on April 30, 2000 due to cardiomyopathy.[1] AR 128, 149. Her doctor, Raj. C. Patel, M.D., described plaintiff's symptoms as general fatigue and shortness of breath on exertion. AR. 128. Plaintiff's cardio-

[1] Cardiomyopathy is a condition causing weakness in the heart muscle.

myopathy was related to her job as sales manager for Sears. AR 153. Plaintiff also suffered from cardiac arrhythmias, and required the use of an implanted cardiac defibrillator ("ICD"). AR 96, 121. Plaintiff submitted her disability claim on June 20, 2000. AR 156. MetLife approved her claim, and plaintiff began receiving long term disability benefits in September 2000 after completing the 140-day elimination period.

On August 11, 2000, plaintiff filed for social security disability benefits ("SSDB"). AR 195. Following a hearing on her claim held March 13, 2002, an administrative law judge issued a decision finding claimant was disabled effective April 30, 2000 (AR 195), and entitled to SSDB beginning October 2000. AR 186.

In addition to use of the ICD, plaintiff's cardiomyopathy was treated with medications. During the two years plaintiff received LTD benefits, plaintiff's medical condition improved with treatment. In December 2000, plaintiff was described by her doctor as "clinically well" (AR 121) and in November 2001 as "stable." AR 110. In March 2000, when she became disabled, her "ejection fraction" was at 25%.[2] AR 129. By April 2001, her ejection fraction had improved to 40-50%, which is where it had been prior to going on disability. AR 115, 129.

In March 2002, MetLife sent Dr. Patel a letter asking him about plaintiff's ability to return to work. AR 105. At MetLife's request, Dr. Patel completed a physical capacity evaluation in which he indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two hours. *Id.* Dr. Patel was also specifically asked whether

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[2] An ejection fraction is the percentage of blood pumped out of the heart chamber during each heartbeat. Typically, the left ventricle pumps 55-75% of the blood within that chamber out to the body with each heartbeat. An ejection fraction below 40% indicates heart failure or cardiomyopathy.

plaintiff was able to work fulltime at a sedentary physical exertion level occupation, and he checked "yes." *Id.*

Three months later, Dr. Patel completed another physical capacity evaluation. AR 99. At that time, he indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two to four hours. *Id.* He also indicated that plaintiff could lift and carry up to ten pounds occasionally, and engage in other activities. *Id.*

MetLife reviewed plaintiff's claim in July 2002 to determine her continued eligibility for benefits. MetLife had her file reviewed by Dr. Mark Moyer, an independent physician consultant who is board certified in internal medicine. Dr. Moyer concurred with Dr. Patel that plaintiff could perform sedentary work. AR 39. Plaintiff's file was then referred to a vocational rehabilitation coordinator for a transferable skills and labor market analysis ("TSA"). *Id.* Taking into consideration plaintiff's education, background, training, and physical capacity, the vocational coordinator concluded that there were alternative sedentary occupations available in plaintiff's geographic area that plaintiff would be able to perform. AR 151-2. These alternative occupations included account information clerk, attendance clerk, and classified ad clerk. *Id.*

Plaintiff's LTD benefits were paid through September 16, 2002, which was the twenty four months after she received her first LTD benefit payment. AR 53. To be eligible for benefits after twenty four months, plaintiff not only had to be disabled from performing her own job, but also from performing any other occupation for which she was reasonably qualified. AR 14. Based on Dr. Patel's opinion that plaintiff could perform sedentary work, and based further on the results of the vocational TSA, MetLife concluded that plaintiff could perform alternate sedentary occupations, and plaintiff was advised in a letter dated July 15, 2002 that her last day of benefits would be September 16, 2002. AR 41, 72.

By letter dated July 26, 2002, plaintiff requested that MetLife reconsider its decision to terminate her benefits. AR 72. In a letter dated July 22, 2002, Dr. Patel stated that plaintiff "continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychological stress at work causes significant problems with her cardiovascular condition . . ." AR 91. Dr. Patel further stated in this same letter "the patient has tried to return to work in the past with exacerbation of her symptoms as well as . . . her condition." *Id.* Dr. Patel concluded that plaintiff "should not be forced to return to . . . even sedentary work . . ." *Id.*

MetLife then re-evaluated plaintiff's claim and concluded that benefits were not payable after September 16, 2002. Plaintiff was advised of this decision in a four-page letter dated August 28, 2002. AR 66-69. In this letter, MetLife noted that Dr. Patel previously found that plaintiff was able to work; that plaintiff's medical records supported the conclusion that plaintiff's condition was stable and plaintiff was able to perform fulltime sedentary work; and that the TSA performed by MetLife's vocational rehabilitation coordinator found alternative job positions available in the geographic area that met plaintiff's education, training, and medical capabilities. AR 67-8. MetLife informed plaintiff that she had the right to submit a written request to appeal the decision terminating her LTD benefits. AR 69.

On February 12, 2003, plaintiff, through counsel, appealed the termination of her disability benefits. AR 59. In support of her appeal, plaintiff submitted a new medical report from Dr. Patel, dated February 12, 2003, in which Dr. Patel stated:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomatology, there was never a time where I felt that this patient would be able to return to full-time employment.

AR 90.

Metlife referred plaintiff's medical records to Chandrakant Pujara, M.D., F.A.C.C., an independent physician consultant board certified in cardiology. In a report dated May 2, 2003, Dr. Pujara found "with the appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." AR 86. Dr. Pujara stated that plaintiff "has been relatively free of any significant cardiac compensation as documented by Dr. Patel's follow up notes." AR 85. Dr. Pujara then concluded that plaintiff was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." *Id.* Dr. Pujara further opined:

> However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional distress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

AR 86.

After it received Dr. Pujara's report, MetLife affirmed its earlier decision to terminate plaintiff's benefits effective September 16, 2002. MetLife concluded:

> We have determined that the documentation currently in the file does not support a disability that would prevent Ms. Glenn from performing any occupation, as defined in the Plan. Therefore, the original claim determination was appropriate.

AR 54. Plaintiff filed the instant action on June 23, 2003.

II. Standard of Review

An ERISA administrator's denial of benefits under a plan is subject to *de novo* review unless the plan grants the administrator discretionary authority either to determine benefits or construe the terms of the plan. *Firestone Tire &*

Rubber Co. v. Bruch, 489 U.S. 101, 103 (1989). If the plan grants the administrator such discretion, the denial of benefits is subject to the highly deferential arbitrary and capricious standard of review. *Firestone*, 489 U.S. at 115.

Here, plaintiff expressly concedes that the plan grants the administrator discretion and that the plan administrator's decision is subject to the arbitrary and capricious standard of review. "[T]he arbitrary and capricious standard is the least demanding form of judicial review of administrative action." *Williams v. International Paper Co.*, 227 F.3d 706, 712 (6th Cir. 2000) A decision regarding eligibility for benefits is not arbitrary and capricious if it is "rational in light of the plan's provisions." *Daniel v. Eaton Corp.*, 839 F.2d 263, 267 (6th Cir. 1988). Stated differently, "[w]hen it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989) (internal quotations and citation omitted). The administrator's decision must be upheld if "it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Baker v. United Mine Workers of Am. Health and Retirement Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991).

> Nevertheless, merely because our review must be deferential does not mean our review must also be inconsequential. While a benefits plan may vest discretion in the plan administrator, the federal courts do not sit in review of the administrator's decisions only for the purpose of rubber stamping those decisions. As we observed recently, "[t]he arbitrary-and-capricious . . . standard does not require us merely to rubber stamp the administrator's decision." *Jones v. Metropolitan Life Ins. Co.*, 385 F.3d 654, 661 (6th Cir. 2004) (citing *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003)). Indeed, "[d]eferential review is not no review,

> and deference need not be abject." *McDonald*, 347 F.3d at 172. Our task at all events is to "review the quantity and quality of the medical evidence and the opinions on both sides of the issues." *Id.*

Moon v. Unum Provident Corp., 405 F.3d 373, 378-79 (6th Cir. 2005).

The Sixth Circuit has recognized that an actual conflict of interest exists when an insurer both decides whether an employee is eligible for benefits and pays those benefits. *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003). "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co.*, 489 U.S. 101, 115 (1989)(quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). In the instant case, defendants decide whether a claimant is eligible for benefits, and pays those benefits. A conflict of interest therefore exists which must be considered as a factor when applying the abuse of discretion standard. The Court will consider and weigh this factor throughout the following discussion.

III. Discussion

Plaintiff argues that MetLife's decision to terminate her LTD benefits must be overturned in light of the arguments asserted by plaintiff's attorneys before the ALJ and the ALJ's finding that plaintiff was disabled. For this proposition, plaintiff relies primarily upon *Ladd v. ITT Corp.*, 148 F.3d 753 (7th Cir. 1998)(opinion by Posner, J.). The Sixth Circuit Court of Appeals summarized Ladd as follows:

> [I]n *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998), the Seventh Circuit held that the plan administrator's denial of disability benefits was arbitrary and capricious where none of the physicians who exam-

ined the plaintiff found that she was capable of working; the insurance company encouraged and assisted the plaintiff in applying for Social Security disability benefits, which were granted after an administrative law judge found that the plaintiff was totally disabled; and the plaintiffs condition was worse when the plan administrator denied her benefits under the plan than when she was granted Social Security benefits. In that case, after the plaintiff was awarded Social Security disability benefits, she was referred by MetLife to a doctor who worked for Network Medical Review Company, the same company employed by Fortis in this case. Without examining the plaintiff, the doctor for Network Medical Review concluded "in a perfunctory report that Ladd had sufficient 'residual, functional capacities' to work a full eight-hour day at a sedentary job." *Id.* at 755. On appeal, the Seventh Circuit found that "[t]he grant of social security benefits" had "additional significance:"

> It brings the case within the penumbra of the doctrine of judicial estoppel — that if a party wins a suit on one ground, it can't turn around and in further litigation with the same opponent repudiate the ground in order to win a further victory. The doctrine is technically not applicable here, because MetLife and ITT, the defendants in this suit, were not parties to the proceeding before the Social Security Administration. Yet they "prevailed" there in a practical sense because the grant of social security benefits to Ladd reduced the amount of her claim against the employee welfare plan. If we reflect on the purpose of the doctrine, which is to reduce fraud in the legal process by forcing a modicum of consistency on a repeating litigant, we see that its spirit is applicable here. To lighten the cost to the employee welfare plan of Ladd's disability, the defendants encouraged and supported her effort to demonstrate total disability to the Social Security Administration, going so far as to pro-

> vide her with legal representation. To further lighten that cost, it then turned around and denied that Ladd was totally disabled, even though her condition had meanwhile deteriorated. In effect, having won once the defendants repudiated the basis of their first victory in order to win a second victory. This sequence casts additional doubt on the adequacy of their evaluation of Ladd's claim, even if it does not provide an independent basis for rejecting that evaluation.

Id. at 756 (citations omitted).

Darland v. Fortis Benefits Ins. Co., 317 F.3d 516, 529-30 (6th Cir. 2003), *overruled on other grounds, Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). Facing similar facts, and following *Ladd*, the court in *Darland* held that the principles of judicial estoppel weighed against the plan administrator taking "inconsistent positions." 317 F.3d at 530.

Here, as in *Ladd* and *Darland*, MetLife encouraged and assisted plaintiff in obtaining SSDB, and an ALJ found that plaintiff was disabled. Nonetheless, the Court finds that *Ladd* and *Darland* are distinguishable. In the instant case, the hearing before the ALJ was held on March 13, 2002. On that same day, plaintiff's treating physician, Dr. Patel, answered "yes" to MetLife's question "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" Dr. Patel's March 13, 2002 response was not part of the record before the ALJ. A statement by plaintiff's own physician indicating that she could perform sedentary work would clearly have been significant to any determination of total disability. MetLife cannot be bound by the proceedings before the ALJ or the ALJ's decision for the simple reason that the records before the ALJ and MetLife were materially different. The Court therefore concludes that *Ladd* and *Darland* are inapplicable.[3]

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[3] Further, it is unclear whether MetLife actually benefited from plaintiff's receipt of SSDB. As plaintiff points out in her reply brief, the Plan

Plaintiff also contends that MetLife was bound by its initial determination of total disability. At the time MetLife made its decision to terminate plaintiff's LTD benefits, the definition of "totally disabled" had changed from "unable to perform each of the material duties of [her] regular job" to include "unable to perform the duties of *any* gainful work . . . ." (emphasis added). Given the change in the definition of "totally disabled", plaintiff's argument is without merit.

Plaintiff additionally argues that it would be unfair to require her to return to work because if she attempts to work but cannot, she would lose her disability coverage. In making this argument, plaintiff refers to the statement of Dr. Pujara, who stated in part:

> However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional distress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

AR 86. Thus, Dr. Pujara acknowledged the possibility that work-related emotional distress could prevent plaintiff from working. MetLife contends that the possibility that plaintiff's return to work may be unsuccessful would not be grounds to continue benefits, as the Plan insures only against actual disabilities, not possible future disabilities. The Court agrees. Read in context, Dr. Pujara's qualification is a recognition that the impact of real or perceived emotional stress is difficult to gauge. It was not an expression that plaintiff was incapable of sedentary work. In any event, the Plan does not alter the definition of "totally disabled" on the basis of a possible loss of coverage.

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gave MetLife the right to deduct SSDB regardless of whether plaintiff applied for them. AR 245.

Plaintiff maintains that the Court should enter judgment in her favor because MetLife did not give her the opportunity to respond to Dr. Pujara's report. Defendants argue that plaintiff was given the opportunity to submit her own supporting evidence in connection with her appeal, and that the plan administrator has the right to review that evidence with the assistance of a consultant. Defendants contend that if plaintiff had been given the opportunity to respond to Dr. Pujara's report with additional evidence, then MetLife would have had the right to seek review of that new evidence by a consultant, and the process would never end.

Plaintiff offers no authority for the proposition that Met Life's use of Dr. Pujara's report violated her rights under ERISA. Inasmuch as the process entails the interpretation of medical evidence, MetLife was entitled to enlist the help of a consultant to review that evidence. To require an opportunity to respond to every consultant's report would unduly burden the process. The Court finds that in the circumstances this case presents, ERISA did not require MetLife to provide plaintiff with a copy of Dr. Pujara's report and an opportunity to respond to the report before it issued its decision on plaintiff's appeal.

Defendants argue that MetLife's decision to terminate plaintiff's LTD benefits was rational and supported by substantial evidence. Plaintiff maintains that there is no evidence to support MetLife's decision.

On March 13, 2002, plaintiff's treating physician, Dr. Patel, answered "yes" to MetLife's question, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" At the same time, Dr. Patel indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two hours.

MetLife also had plaintiff's file reviewed by an independent physician consultant board certified in internal medicine,

Dr. Mark Moyer. Dr. Moyer concurred with Dr. Patel that plaintiff could perform sedentary work.

The vocational coordinator concluded that there were alternative sedentary occupations available in plaintiff's geographic area that plaintiff would be able to perform. These alternative occupations included account information clerk, attendance clerk, and classified ad clerk. In addition to considering plaintiff's physical limitations, the vocational coordinator specifically took into account Dr. Patel's statement that plaintiff should not be subjected to "emotional distress."

In a letter dated February 12, 2003, Dr. Patel stated:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomatology, there was never a time where I felt that this patient would be able to return to full-time employment.

Hence, Dr. Patel expressly acknowledged that he had stated that plaintiff was fit for sedentary work. The Court finds that MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism. *See United States v. Willis*, 257 F.3d 636, 645-46 (6th Cir. 2001)(recognizing that affidavits recanting trial testimony are viewed with "extreme suspicion.").

MetLife also had before it Dr. Pujara's report. Dr. Pujara, a cardiologist, indicated "with the appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." Dr. Pujara stated that plaintiff "has been relatively free of any significant cardiac compensation as documented by Dr. Patel's follow up notes." Dr. Pujara then concluded that plaintiff was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." *Id.* Dr. Pujara additionally stated that plaintiff was "a reasonable candidate to try one of the sedentary job classes at least on a trial basis."

The Court finds that the above constitutes substantial evidence supporting MetLife's determination that plaintiff was no longer totally disabled as the Plan defines that term. Even considering MetLife's conflict of interest, the Court holds that MetLife's decision to terminate plaintiff's LTD benefits was rational and did not constitute an abuse of discretion. Defendants are therefore entitled to judgment in their favor.

IV. Disposition

Based on the above, the Court DENIES plaintiff s motion for entry of judgment and GRANTS defendants' cross-motion for entry of judgment.

The Clerk shall enter a final judgment in favor of defendants and against plaintiff, dismissing this action with prejudice.

The Clerk shall remove this case from the Court's pending cases list.

The Clerk shall remove Doc. 9, Doc. 11 and Doc. 12[4] from the Court's pending CJRA motions list.

IT IS SO ORDERED.

/s/ George C. Smith
GEORGE C. SMITH, JUDGE
United States District Court

[4] Doc. 11 and Doc 12 were improperly designated as motions. Doc. 10, which is a motion for judgment on the administrative record, was not docketed as a motion.

APPENDIX C

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

IN THE CASE OF	CLAIM FOR
Wanda Glenn (Claimant)	Period of Disability and Disability Insurance Benefits
_____ (Wage Earner)	587-84-9884 (Social Security Number)

DECISION

This case is before the undersigned Administrative Law Judge pursuant to a timely request for hearing. The claimant filed her application on August 11, 2000, alleging disability since April 30, 2000. This claim was denied initially on November 21, 2000 and upon reconsideration. After proper notice, a hearing was held on March 13, 2002 in Columbus, Ohio. The claimant appeared and testified and was represented by Valerie Barich. Gordon Snider, M.D., appeared and testified as a medical expert. Michael Klein, Ph.D., appeared and testified as a vocational expert.

ISSUES

The issues are whether the claimant is disabled as defined in the Social Security Act and, if so, when such disability commenced and the duration thereof; and whether the insured status requirements of the Act are met.

CONCLUSION

The claimant met the insured status requirements of the Act at all pertinent times and has been disabled as defined in the Act since April 30, 2000.

EVALUATION OF THE EVIDENCE AND RATIONALE

The claimant was born on December 11, 1952 and is 49 years old. She completed a high school education and past relevant

work was as a retail sales manager, material handler, sales person, teacher's assistant and investigator. In the disability report associated with her application, the claimant alleges the inability to work due to severe dilated cardiomyopathy (Exhibit 1E, p. 2). In the reconsideration disability report, she alleged that she continued to suffer from cardiomyopathy and high blood pressure. She related difficulty with tiredness and dealing with stress (Exhibit 6E, p. 1). At the hearing, the claimant complained of shortness of breath, fatigue and arm pain.

The claimant met the insured status requirements of the Act on April 30, 2000, the alleged onset date of disability, and continues to meet them through at least the date of this decision.

Social Security Regulations (20 CFR 404.1520 and 416.920) require a sequential evaluation process in disability cases. First, an individual who has engaged in substantial gainful activity cannot be found disabled. Second, an individual who does not have a "severe" impairment or combination of impairments is not disabled. Third, if an individual has an impairment that meets or equals the requirements of an impairment listed in Appendix 1 of Subpart P of the Regulations. (20 CFR 404) disability will be found without regard to vocational factors. Fourth, a determination must be made as to whether the claimant can do his or her prior work. If not, the burden shifts to the Commissioner and a fifth determination is made, namely, whether in light of the individual's residual functional capacity, age, education and past relevant work experience, the individual can perform other jobs that exist in significant numbers in the economy.

I find that the claimant has not engaged in substantial gainful activity since the alleged onset date of April 30, 2000.

Briefly, the relevant medical evidence demonstrates that the claimant has a history of systolic dysfunction indicated by

cardiac catheterization in 1993 (Exhibit 1F). Exercise myocardial perfusion scintigraphy in August 1996, demonstrated findings indicating a fixed septal defect consistent with prior myocardial infarction, left bundle branch block and/or AICD patch leads (Exhibit 2F).

More recent medical evidence includes an exercise stress test from March 8, 2000, with a base line electrocardiogram demonstrating left bundle branch block. Cardiac imaging on March 7, 2000 demonstrated left ventricular ejection fraction of 22 percent with findings indicative of underlying severe dilated cardiomyopathy. Cardiac catheterization on March 14, 2000 demonstrated an estimated ejection fraction of 25 percent.

Raj Patel, M.D., the claimant's treating cardiologist, reported on April 19, 2000, that the claimant suffered from severe dilated cardiomyopathy. She had significant difficulty with general fatigue and exertional shortness of breath because of her cardiac condition. He opined that she could not return to any kind of job that would require significant physical or psychological demands.

On June 20, 2000, Carl Leier, M.D., also a treating cardiologist, related the claimant's history including an episode of sudden death in October 1989 from which the claimant was resuscitated. At that time an AICD defibrillator system was placed for the prevention of additional sudden death/ malignant ventricular arrhythmia events. Dr. Leier reported that the claimant had gone on to develop a dilated cardiomyopathy with longstanding systemic hypertension. This condition has left her with biventricular enlargement and dysfunction. The dysfunction was systolic with likely diastolic dysfunction as well in view of the history of hypertension. He graded her overall functional class at that time as II to early III.

On July 28, 2000, Dr. Patel diagnosed the claimant with a history of idiopathic dilated cardiomyopathy and complex

ventricular arrhythmias requiring defibrillator. The claimant was feeling some improvement because of her reduction of stress and strain of work, however, she continued to experience periods of extreme fatigue (Exhibit 5F).

Reports from Choo Rhee, M.D., the claimant's treating internist since 1993, revealed the diagnoses of cardiomyopathy, hypertension, and defibrillator implant. Dr. Rhee opined that the claimant's physical activity was restricted (Exhibits 6F and 10F).

On December 15, 2000, Dr. Patel reported that the claimant continued to have good days and bad days but was mostly remaining out of any significant heart failure. Recently, her ICD was revised and she now had an ICD with three leads and biventricular pacing (Exhibit 9F, p. 2). On August 3, 2001, Dr. Patel reported that she looked clinically well compensated. However, he was concerned about her increasing general fatigue (Exhibits 9F and 11F).

An echocardiograph report of December 19, 2001 demonstrated an estimated ejection fraction of 35 to 40 percent. A pacemaker device was noted in the right heart (Exhibit 22F).

At the hearing, Dr. Snider, a Board-certified internist, testified as a medical expert. This testimony demonstrated a combination of impairments consisting of hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated cardiomyopathy and systolic and diastolic ventricular dysfunction (Exhibit 23F). Dr. Snider opined that the claimant had no impairment or combination of impairments that met or equaled in severity the level of the Listings of Impairments in Appendix 1 to Subpart P of Regulations No. 4. Nevertheless, he opined that the claimant had significant functional loss. That is, the claimant is limited to lifting and carrying occasionally up to 15 pounds at a time and frequently two to three pounds at a time. The claimant could

stand and walk for three to four hours total during the workday. She could walk one half hour at a time for two to three times during the day. She could sit throughout the day with normal breaks. The claimant could only climb stairs at her own pace once or twice during the workday. She could occasionally bend and stoop but could not squat or crawl. She could not be at unprotected heights. The claimant must avoid smoke and fumes, extremes of heat and extremes of humidity. Her ability to operate foot controls is limited to 15 pounds occasionally and two to three pounds frequently. She could not balance. The claimant must avoid exposure to microwaves or electrical discharge. She is limited to low stress work environment.

The foregoing considered, I find that the medical evidence demonstrates the existence of impairments best described as hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated cardiomyopathy and systolic and diastolic ventricular dysfunction. Although these impairments in combination are "severe" they do not meet or equal in severity the level of the listings of Impairments in Appendix 1 to Subpart P, Regulations No. 4, consistent with the testimony of the medical expert at the hearing.

I further find that the claimant is functionally limited as described by the medical expert, whose opinion I accept and adopt.

These impairments and resulting functional limitations are consistent with the medical record. They are as described by the medical expert in his testimony at the hearing. They are further documented by the claimant's extensive medical history and the diagnostic test results and clinical findings of record. They are generally consistent with the medical opinions of the claimant's treating physicians. The claimant's subjective complaints including shortness of breath and fatigue are supported by the medical opinions and medical

findings of record and are considered credible. The claimant's credibility is further enhanced by her excellent work and earnings record.

The record contains residual functional capacity assessments relating to the claimant completed by physicians employed by the State Disability Determination Services ("DDS"). Those opinions were relied on in denying the claimant's application at the initial and reconsideration levels, and conflict with the residual functional capacity finding reached in this decision. The main reason for not adopting those opinions is that new persuasive evidence regarding the nature and severity of the claimant's impairments has been received, including extensive treatment records from treating sources as well as the testimony of the medical expert at the hearing. It is quite possible that the DDS opinions would differ had those physicians had the opportunity to evaluate that new evidence.

The remaining issue is whether the claimant's impairments prevent her from performing past work or other kinds of substantial gainful activity. The claimant bears the burden of showing inability to perform her prior work, but once this burden is met it shifts to the Commissioner to show that there are other jobs that the claimant can perform which exist in significant numbers in the economy.

Dr. Klein, the vocational expert at the hearing, identified the claimant's prior jobs a retail sales manager, material handler, sales person, teacher's assistant and investigator. The prior jobs as a sales person, teacher assistant and investigator were all exertionally light and semi-skilled. The prior job as the retail sales manager was exertionally light and skilled and the work as a material handler was exertionally medium and unskilled. The testimony of the vocational expert is consistent with the description of the jobs in the *Dictionary of Occupational Titles*.

Consistent with the claimant's impairments and resulting functional limitations, the vocational expert opined that indi-

viduals so impaired could not perform any of the claimant's past relevant work. The vocational expert identified no transferable skills to other skilled or semi-skilled jobs within the claimant's residual functional capacity. Considering the claimant's residual functional capacity and her vocational profile, the vocational expert opined that this indicated a non-competitive work capacity. That is, the vocational expert opined that this combination of functional limitations would effectively preclude the performance of full-time competitive employment. The testimony of the vocational expert is considered accurate and is accepted and adopted.

Accordingly, I find that the claimant has been prevented by her impairments and resulting functional limitations from performing any past relevant work. She has not acquired transferable skills to other skilled or semi-skilled work within her residual functional capacity. Considering the claimant's residual functional capacity and her vocational profile, the claimant is prevented from performing any jobs existing in significant numbers in the national economy consistent with the testimony of the vocational expert. The claimant then, has been disabled as defined in the Social Security Act since April 30, 2000, pursuant to 20 CFR 404.1520(f).

FINDINGS

1. The claimant met the insured status requirements of the Act on April 30, 2000, the alleged onset date of disability, and continues to meet them through at least the date of this decision.

2. The claimant has not engaged in substantial gainful activity since April 30, 2000.

3. The claimant has a severe combination of impairments consisting of hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated

cardiomyopathy and systolic and diastolic ventricular dysfunction.

4. The claimant has no impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, to Subpart p of Regulations No. 4.

5. The claimant's subjective complaints have been carefully considered and are felt to be reasonably supported by the medical record and generally credible.

6. The claimant's impairments since April 30, 2000 have limited her to lifting and carrying occasionally up to 15 pounds at a time and frequently two to three pounds at a time. The claimant could stand and walk for three to four hours total during the workday. She could walk one half hour at a time for two to three times during the day. She could sit throughout the day with normal breaks. The claimant could only climb stairs at her own pace once or twice during the workday. She could occasionally bend and stoop but could not squat or crawl. She could not be at unprotected heights. The claimant must avoid smoke and fumes, extremes of heat and extremes of humidity. Her ability to operate foot controls is limited to 15 pounds occasionally and two to three pounds frequently. She could not balance. The claimant must avoid exposure to microwaves or electrical discharge. She is limited to low stress work environment.

7. The claimant's impairments and resulting functional limitations prevent the performance of any past relevant work.

8. The claimant is a younger person and has a high school education.

9. The claimant has a history of skilled and semi-skilled work but has not acquired transferable skills to other skilled or semi-skilled work within her residual functional capacity.

10. Considering the claimant's residual functional capacity and her vocational profile, she is prevented from performing any jobs existing in significant numbers in the national economy, consistent with the testimony of a vocational expert.

11. The claimant has been disabled as defined in the Social Security At since April 30, 2000 pursuant to 20 CFR 404.1520(f)

DECISION

Based on the application filed August 11, 2000, the claimant is entitled to a period of disability commencing April 30, 2000, and to disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act, and the claimant's disability has continued through the date of this decision.

/s/ Thomas P. Piliero
THOMAS P. PILIERO
Administrative Law Judge

April 22, 2002
Date